No. _____

In The

Supreme Court of the United States

October Term, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,

Petitioner,

v.

SECRETARY OF HHS,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

DIANA L. GUSTIN
Counsel of Record
11 Town Square
Post Office Box 1349
Norris, Tennessee 37828
(423) 494-3000
Counsel for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

95 pp

QUESTIONS PRESENTED FOR REVIEW

I. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under:

- 42 U.S.C. § 1395oo
- 28 U.S.C. § 1331
- 28 U.S.C. § 1361
- 5 U.S.C. § 706

II. Is regulation 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare statute?

III. Does the Secretary's interpretation of the Medicare statute and the regulation which prohibits review constitute a deprivation of due process under the United States Constitution, Amendment V?

IV. In the event that petitioner prevails, is there justification for an award of attorneys fees under the Equal Access to Justice Act 5 U.S.C. § 504 and 28 U.S.C. § 2412, because the Government's action was not substantially justified?

PARTIES TO THE PROCEEDINGS

The petitioner, plaintiff-appellant in the proceeding below, is Your Home Visiting Nurse Services, Inc. and its home health care agency providers licensed as numbers 44-7100, 44-7300, 44-7234, and 44-7304 (Tennessee corporations). There is no parent or non-wholly owned subsidiary company to be listed as required by United States Supreme Court Rule 29.6.

Respondent is the Secretary of Health and Human Services, represented by Counsel for the Department of Health and Human Services.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES – Continued

Page

STATUTES, CONSTITUTIONAL PROVISIONS, AND RULES INVOLVED

TABLE OF AUTHORITIES – Continued

PETITION FOR WRIT OF CERTIORARI

Your Home Visiting Nurse Services, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*,) is reported at 1997 U.S. App. LEXIS 35873. The opinion of the district court (App., *infra*,) is unreported.

STATEMENT OF JURISDICTION

The court of appeals for the Sixth Circuit entered its judgment on December 22, 1997 (App., *infra*,). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND OTHER AUTHORITIES INVOLVED

The statutory provisions and other authorities involved include: 5 U.S.C. § 504; 5 U.S.C. § 706; 28 U.S.C. § 1254(1); 28 U.S.C. § 1331; 28 U.S.C. § 1361; 28 U.S.C. § 2412; 42 U.S.C. § 405(h); 42 U.S.C. § 1395x(v)(1)(A)(ii); 42 U.S.C. § 1395oo; U.S. Const. amend. V; 42 C.F.R. § 405.1885; 42 C.F.R. § 421.5(b).

STATEMENT OF THE CASE

The petitioner provides home health services to Medicare beneficiaries and receives reimbursement from Medicare. The Medicare Program is administered by the United States Department of Health and Human Services. Annual cost reports are submitted to fiscal intermediaries such as Blue Cross and Blue Shield of South Carolina, an agent of the Secretary of Health and Human Services.

The petitioner discovered new and material evidence that suggested the 1989 cost reports should be reopened. Within the appropriate time period (three years from the date of the Notice of Program Reimbursement letters which had closed the 1989 cost reports) the petitioner made requests for reopening. Blue Cross refused to reopen the cost reports. Petitioner appealed the denial to reopen the cost reports to the Provider Reimbursement Review Board. The Board would not accept jurisdiction of the case. Petitioner appealed the Board's decision to the district court, where the case was dismissed and the Board's decision was upheld. The district court also determined that it did not have the authority to review the fiscal intermediary's refusal to reopen the cost reports by resorting to alternative theories of jurisdiction. The Sixth Circuit Court of Appeals affirmed the district court decision.

REASONS FOR GRANTING THE WRIT

I. The Sixth Circuit decision is in conflict with the decision of other United States Court of Appeals.

The petitioner respectfully requests Supreme Court review of the latest decision in a line of conflicting cases regarding the right to judicial review. During the years 1984 through 1997, six separate decisions were rendered on this question of law. In *Your Home Visiting Nurse Services, Inc. v. Shalala*, No. 96-5525 (6th Cir. Dec. 22, 1997), the Sixth Circuit Court of Appeals has effectively joined with the Second Circuit and the District of Columbia Circuit to deny judicial review of a refusal to reopen a Medicare cost report.

In this case, an employee of an insurance company made a decision which thus far has been insulated from judicial review. The insurance company who employed this individual contracts with the Health Care Financing Administration to act as the fiscal intermediary and agent of the Secretary of Health and Human Services in administering Medicare reimbursement. The intermediary (through the insurance company employee) refused to grant petitioner's request to reopen its Medicare cost reports. Petitioner asserts that the refusal to reopen the cost report was arbitrary, capricious, and otherwise inappropriate under the law.

The Sixth Circuit Court of Appeals' decision perpetuates the dispute among the circuit courts on this issue. Six federal court cases referenced below examined some of the same key provisions of the Medicare statute:

- 42 U.S.C. § 1395oo(a) (West Supp. 1996) – appeal process for providers dissatisfied with a final determination
- 42 U.S.C. § 1395x(v)(1)(A)(ii) (West Supp. 1997) – reasonable cost, regulations, retroactive corrective adjustments
- 42 U.S.C. § 405(h) (West Supp. 1997) – finality of Secretary's decision

Nevertheless, the courts are not in agreement.

The Ninth Circuit Court of Appeals addressed this question in 1988, holding that review is available under 42 U.S.C. § 1395oo(a) and that the Provider Reimbursement Review Board has jurisdiction to review the fiscal intermediary's decision not to reopen a cost report. *Oregon v. Bowen*, 854 F.2d 346 (9th Cir. 1988). As a result of that decision, providers located within the Ninth Circuit have a right to obtain review of a refusal to reopen a cost report by appeal to the Provider Reimbursement Review Board. (Providers may then obtain judicial review of the Secretary's final determination after completion of the administrative review process outlined in the statute.) The Provider Reimbursement Review Board manual contains a provision which allows review of this issue **if**, and only if, the provider is located in the Ninth Circuit:

> Refusal to Reopen. – A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 1885(c), except for providers which are located within the jurisdiction of the U.S. Ninth Circuit Court of Appeals, where such a refusal to reopen is appealable. In such Ninth Circuit cases, the issue to be heard by the Board is whether the intermediary abused its discretion in refusing to reopen such determination or decision.

Prov. Reimb. Man., Part I, § 2926.6.

In *Oregon*, 854 F.2d 346, the court recognized the plain meaning of 42 U.S.C. § 1395oo(a) entitled the provider to review of a refusal to reopen the cost report. Petitioner urges this Court to accept this petition to resolve the dispute as to the plain meaning of the statute:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished . . .
>
> . . .
>
> . . .
>
> . . .
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

42 U.S.C. § 1395oo(a).

An intermediary's refusal to reopen a cost report is a final determination. It is not a temporary decision scheduled for a later review, but is, admittedly, final. "Although the NPR is often the final determination in question, the fiscal intermediary's refusal to reopen also qualifies as a final determination, a fact the Secretary concedes in his briefs." *Oregon*, 854 F.2d at 349.

While the Eighth Circuit Court of Appeals has not yet ruled on the precise question of judicial review of an intermediary's *refusal to reopen* a Medicare cost report, in 1996 it did remand a case back to the district court for additional findings of fact regarding circumstances required to validate the intermediary's *decision to reopen* a cost report. *Hennepin County Medical Center v. Shalala*, 81 F.3d 743 (8th Cir. 1996). The court questioned the existence of *new and material information* sufficient to justify the intermediary's *decision to reopen* the cost reports. *Id.* These questions were to be answered by the district court through further proceedings. *Id.* The Eighth Circuit has obviously decided that a district court has the right to review the reopening process. The *Hennepin* court made reference to *Oregon*, 854 F.2d 346, the Ninth Circuit case which allows review of a refusal to reopen a cost report.

In 1984, four years before the Ninth Circuit decision on the matter, the District of Columbia Circuit Court of Appeals ruled on the issue of judicial review for a refusal to reopen a cost report. In *St. Mary of Nazareth Hospital Center v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984), the court held that 42 C.F.R. § 405.1885(c) makes denials of reopenings *unreviewable*. Nevertheless, in 1991, a district court *within the District of Columbia Circuit* acknowledged jurisdiction to review an intermediary's refusal to reopen

a cost report by virtue of the federal question statute, 28 U.S.C. § 1331, and the mandamus statute, 28 U.S.C. § 1361. *Memorial Hospital v. Sullivan*, 779 F. Supp. 1406 (D.D.C. 1991).

The district court in *Memorial Hospital* found alternative sources to allow review of an intermediary's refusal to reopen cost reports. *Id.* The district court felt it was inappropriate for the Secretary to direct providers not to appeal to the Provider Reimbursement Review Board, but instead to file for reopening of their cost reports to include self-disallowed data, only to have the request for reopening denied. *Id.*

> [T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the Court may invoke its federal question jurisdiction and mandamus power.

Id. at 1412.

Based upon the record presented in that case, the court found that the intermediary acted arbitrarily, capriciously, and abused its discretion in denying the plaintiff's request to reopen the cost reports citing the HHS regulation and Provider Reimbursement manual sections which require a reopening in the event that "new and material evidence has been submitted." *Id.* at 1412-13. Because there was new evidence and an inconsistency of law, there was a basis for reopening. This fact is important since even the District of Columbia Circuit recognized that reopening is permitted to hear new *evidence*.

St. Mary of Nazareth, 741 F.2d at 1449 (citing *Community Hospital v. Schweiker*, 686 F.2d 989, 996 (D.D.C. 1982) (emphasis in original)). The same reasoning was set forth by this Court in the case of *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987). "If review of denial to reopen for new evidence or change in circumstance is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration – even on a 'clearest abuse of discretion' basis – of facts which, through no fault of his own, the original proceedings did not contain." *Id.* at 270.

The Second Circuit Court of Appeals did not accept the *Oregon* explanation of the plain meaning of the statute. *Good Samaritan Hospital Regional Medical Center v. Shalala*, 85 F.3d 1057 (2nd Cir. 1996). Instead, the Second Circuit endorsed the game of statutory construction played by a district court in the Southern District of New York:

> While . . . a decision not to reopen is in some sense "final," it does not in and of itself establish an "amount of total reimbursement." Instead it is a final determination that there are not grounds on which to reconsider a previous final determination as to the amount of total program reimbursement.

Good Samaritan, 85 F.3d at 1061 (citing *Good Samaritan Hospital*, 894 F.Supp. at 690 (complete citation omitted in original) (citing *Staten Island Hospital v. Sullivan*, No. 91-Civ-733, 1992 WL 675952, at 5 n. 6 (D.D.C. Mar. 31, 1992))).

The *Good Samaritan* court position is not, in petitioner's view, a reasonable reading of the statute. Moreover, it neglects to address the heart of the problem. If the

refusal to reopen is not a final determination for purposes of appeal, but is a final determination that there are not grounds on which to reconsider a previous final determination, what recourse is available to the provider with valid grounds for the reopening, whose reopening request is denied? The rationale put forth in *Good Samaritan* leaves a provider wrongfully denied a reopening with no remedy or redress. These cases present two questions for this Court to resolve:

1. Which construction of 42 U.S.C. § 1395oo(a) is correct?

2. Is there an alternative basis for jurisdiction to review a refusal to reopen a Medicare cost report?

II. There is a presumption of judicial review.

This Court has not yet reviewed the question of a Medicare provider's right to judicial review of the refusal to reopen a cost report. However, two conflicting decisions from this Court were repeatedly cited for opposing propositions by the parties herein. In 1977, this Court held there is no review for a refusal to reopen a previously adjudicated claim for social security benefits under section 10 of the Administrative Procedure Act. *Califano v. Sanders*, 430 U.S. 99 (1977). Ten years later, this Court ruled on the reopening question again, but stated that: "only when a petition to reopen and reconsider an agency order alleges new evidence or changed circumstances is the agency's refusal to reopen subject to judicial review, and then, only as to whether such refusal was arbitrary,

capricious, or an abuse of discretion." *Interstate Commerce Commission*, 482 U.S. at 271.

This Court has long recognized the strong presumption of judicial review dating back to the year 1803 when Chief Justice Marshall insisted that "the very essence of civil liberty certainly consists in the right of every individual to claim protection of the laws." *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 670 (1986) (citing *Marbury v. Madison*, 1 Cranch 137, 163, 2 L. Ed. 60 (1803)). In 1835, the Chief Justice again noted the traditional observance of this right which has laid the foundation for our modern presumption of judicial review:

> "It would excite some surprise if, in a government of laws and of principle, furnished with a department, whose appropriate duty it is to decide questions of right, not only between individuals, but between the government and individuals; ***a ministerial officer might, at his discretion, issue this powerful process . . . leaving the debtor no remedy, no appeal to the laws of his country,*** if he should believe the claim to be unjust. But this anomaly does not exist; this imputation cannot be cast on the legislature of the United States."

Id. (citing *United States v. Nourse*, 9 Pet. 8, 28-29, 9 L. Ed. 31 (1835) (emphasis added)). The Court in *Michigan Academy* goes on to point out that:

> Committees of both Houses of Congress have endorsed this view. In undertaking the comprehensive rethinking of the place of administrative agencies in a regime of separate and divided powers that culminated in the passage of the Administrative Procedure Act (APA) . . . the

> Senate Committee on the Judiciary remarked: ***"Very rarely do statutes withhold judicial review.*** It has never been the policy of Congress to prevent the administration of its own statutes from being judicially confined to the scope of authority granted or to the objectives specified. Its policy could not be otherwise, for in such a case statutes would in effect be blank checks drawn to the credit of some administrative officer or board."

Id. at 670-71 (citing S. Rep. No. 79-752, at 26 (1945) (emphasis added)). More evidence was offered by the court in *Michigan Academy, id.* at 671, through review of the H.R. Rep. No. 79-1980, at 41 (1946) where the committee on the Judiciary of the House of Representatives agreed that Congress intends that there be judicial review, and emphasized the clarity and precision with which a contrary intent must be expressed.

In the petitioner's case, the statute at issue expressly provides for judicial review of final determinations, though it does not expressly define a refusal to reopen a cost report as being a final determination which can be appealed. 42 U.S.C. § 1395oo(a). The statute sets out the method for obtaining judicial review when a provider is dissatisfied with a final determination related to Medicare reimbursement. *Id.* While the statute does not preclude judicial review, the Secretary of Health and Human Services cuts off any review process through a regulation which is interpreted to preclude judicial review. The regulation at issue is 42 C.F.R. § 405.1885(c) (1997) which states that "jurisdiction for reopening a determination or decision rests exclusively with the administrative body that rendered the last determination or decision."

Although the language of the regulation does not expressly prohibit review of the determination, the Secretary's interpretation of the regulation does. The manual which the Secretary of HHS provides to her agents as direction for the implementation of the law clearly shows the Secretary intends to deny review:

> Notice of Refusal to Reopen or Correct. – A provider has no right to a hearing on a finding by an intermediary or a hearing officer that a reopening or correction of a determination or decision is not warranted. Accordingly a hearing paragraph should not be included in any letter or notice setting forth such a finding. The notice will, however, explain the basis for refusing to reopen or correct the determination or decision and will be issued by the intermediary, hearing officer, PRRB or the Secretary having responsibility for the reopening according to 2931.

Prov. Reimb. Man., Part I § 2932.1.

As a result of these instructions, even in the most egregious circumstances, an intermediary's refusal to reopen a cost report will not be reviewed in any manner, and certainly not by the Provider Reimbursement Review Board, *unless the provider is fortunate enough to be located within the Ninth Circuit Court of Appeals jurisdiction.* Providers within the Ninth Circuit must be aware of their right to request review based upon the Ninth Circuit Court of Appeals decision because the Secretary of HHS does not inform them of their right to review. Regardless of the magnitude of injustice committed by an intermediary's refusal to allow a reopening, there is no recourse for

a provider *unless they are located within the Ninth Circuit Court of Appeals district and know the Ninth Circuit law.*

This Court reviewed the Medicare statute in 1986 and ruled that judicial review was warranted in *Michigan Academy*, 476 U.S. 667. Many of the same sections of the Medicare statute which led this Court to grant judicial review in that case have been addressed by the lower court decisions which led to this petition for certiorari. The continuing relevance of the *Michigan Academy* ruling was questioned by the Sixth Circuit Court of Appeals. (App. 1) The competing constructions of the statutes and the Supreme Court decisions should be addressed by this Court. There is an obvious need for this Court to come to a final conclusion on this question and end the disparity between the federal courts which exists today. The map at page 54 of the Appendix demonstrates the impact of this dilemma upon the nation.

The petitioner in the present case offered new and material evidence in support of its request to reopen the 1989 Medicare cost reports. Therefore, petitioner demonstrated circumstances to justify reopening. Unfortunately, this evidence was not examined by the Provider Reimbursement Review Board, the U.S. District Court for the Eastern District of Tennessee, or the Sixth Circuit Court of Appeals due to their refusal to accept jurisdiction of this case to either hear the merits of the petitioner's argument or to remand the case to the appropriate forum to hear the merits of the petitioner's allegations that the intermediary acted arbitrarily and capriciously in its refusal to reopen the cost reports. A reviewing court should set aside agency action that is arbitrary, capricious, and an abuse of discretion. 5 U.S.C. § 706 (West 1996).

The petitioner asserts that the evidence offered was sufficient to justify the re-opening of the cost report with a suitable retroactive adjustment. The Medicare statute requires the Secretary of HHS to promulgate regulations for the implementation of such corrective adjustments. 42 U.S.C. § 1395x(v)(1)(A)(ii). The court in *Oregon,* 854 F.2d at 349 recognized this section of the statute as authority for the reopening regulation: "[n]othing in the plain language of this mandate indicates unreviewability." It is the Secretary's regulation that prohibits review of the intermediary's failure to make an appropriate retroactive corrective adjustment. The standard for assessing the validity of federal regulations appears in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 476 U.S. 837, 842-843 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress. If, however, the court determines congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Some regulations are considered unreasonable and therefore fail the second prong of the standard as stated in *Chevron*. The petitioner urges this Court to accept this case in order to examine the Secretary's regulation at 42 C.F.R. § 405.1885(c) for the purpose of determining whether the regulation is a permissible construction of the relevant portions of the Medicare statute.

By accepting this case, this Court will have the opportunity to resolve the statutory construction questions and also address the continuing viability of the Court's decision in *Michigan Academy,* 476 U.S. 667, a case which petitioner asserts is controlling law for this controversy.

In *Michigan Academy,* physicians challenged the validity of a federal regulation which authorized payment of benefits under Part B of the Medicare program in different amounts for similar services. *Id.* Obviously, the physicians who were receiving less reimbursement for rendering similar services did not find the regulation acceptable. The district court held that this regulation, to the extent that it authorized different reimbursement rates for certain physicians, contravened the Medicare statute. The Sixth Circuit expressed the view that:

> (1) the regulation was invalid due to its failure to recognize a statutory mandate that similar physician's services be considered identically, and (2) judicial review was not precluded whether by 42 U.S.C. § 405(h) as incorporated into the Medicare program under 42 U.S.C. § 1395ff.

Id. at 667. Before *Michigan Academy* was heard at the Supreme Court level, the Sixth Circuit had ruled favorably with regard to the question of the availability of

judicial review and had also reaffirmed its conclusion, after further proceedings, reiterating for a second time that ***the validity of the regulation was subject to judicial review***. On Certiorari, this Court affirmed the Sixth Circuit's decision, without deciding the merits as to the validity of the regulation, holding that ***judicial review of the validity of a regulation is not precluded by Section 1395ff or Section 405(h).*** *Id.*

There are some striking similarities between the complaint of the physicians in *Michigan Academy* and the petitioner's complaint herein. Both addressed the unfairness of being paid different amounts for the same services. In *Michigan Academy*, 476 U.S. 667, doctors were being paid different amounts. In this case, a nurse and her husband, owners of a Medicare home health agency provider, were being paid less than other owners of home health agencies within the same geographical region. Petitioner is the Medicare Provider that was owned and operated by the nurse and her husband. Owners of providers are entitled to a reasonable amount of compensation for their salary. Each year the fiscal intermediary reviews costs of the provider, including owners' compensation. A dispute arose in the 1980s concerning the appropriate amount of owners' compensation which Medicare would consider allowable reasonable cost. Like the physicians in *Michigan Academy*, the petitioner felt it was unfair to receive less compensation for its owners' salary than the intermediary allowed for their competitors. In *Michigan Academy*, the regulation itself allowed different payment for the same services. *Id.* In the petitioner's case, there is an employee of the intermediary (an insurance company) which allows different payment to be made for

the same services. This was accomplished in part by an intermediary's use of a secret salary survey. Unbeknownst to the petitioner, an intermediary had developed a salary survey for use in determining the amount of salary it would consider allowable for a home health agency owner. The intermediary did not tell the petitioner about this salary survey. Once this salary survey was discovered and the petitioner realized its owners had not been paid as much as competitors were paid for the same type of position, petitioner requested reopening of the 1989 cost reports. The nurse and her husband realized they had not received a fair payment in comparison with their peers. This is a violation of the Medicare statute and Medicare regulations, just like the situation in *Michigan Academy* was a violation of the Medicare statute. "The Sixth Circuit Court of Appeals affirmed and expressed the view that (1) the regulation was invalid due to its failure to recognize a statutory mandate that similar physician's services be considered identically." *Michigan Academy*, 476 U.S. at 667.

Although a specific *regulation* did not prescribe the inappropriate payment in the petitioner's case, the resulting injustice is the same. While different regulations are in controversy, the basic theme and subject matter in the two cases are quite similar. The regulation at issue in petitioner's case is 42 C.F.R. § 405.1885(c). This regulation does not allow for a review of the intermediary's refusal to reopen the cost report to correct this error concerning the owners' compensation. This Court will surely agree that if it was unfair for physicians who rendered similar services to be paid different amounts then it is also unfair

for owners of a provider to be paid less than their competitors. Without a review of the intermediary's refusal to reopen the cost reports, there is no remedy for this situation.

In *Michigan Academy*, 476 U.S. 667, the physicians complained about the regulation. Not only was the validity of the regulation at issue, but more important for the purposes of consideration of this Writ, *jurisdiction to review the complaint about the regulation* was at issue. *Id.* This Court carefully reviewed the Medicare statute to address questions raised by Section 405(h) concerning jurisdiction. *Id.* (Generally, Section 405(h) is perceived as a bar to federal court jurisdiction when litigants want to shortcut the administrative appeal process by immediate resort to the judiciary.) On appeal to this Court, the Secretary of HHS did not seek review of the Sixth Circuit court's decision in *Michigan Academy* as to the merits of the regulation invalidated. *Id.* Instead, the Secretary renewed the contention that Congress had forbidden judicial review of all questions affecting the amount of benefits payable under Part B of the Medicare program. *Id.* On certiorari, this Court reviewed the appeal process available to individuals who felt they had received less than the appropriate amount of Part B benefits. *Id.* (At that point in time, a more limited review process was available for Part B amount determinations.) The Secretary took the position that Congress had deliberately intended to foreclose further review of part B claims, and urged this Court to accept this position and thus deny the litigants review of the regulation at issue. *Id.* This Court held that the plaintiff's in *Michigan Academy* had mounted

a challenge to the Secretary's regulation, an action which was not foreclosed by Section 1395ff.

> The reticulated statutory scheme, which carefully details the forum and limits of review of "any determination . . . of . . . the amount of benefits under part A," and of the "amount of . . . payment" of benefits under Part B, simply does not speak to challenges mounted against the method by which such amounts are to be determined rather than the determinations themselves. As the Secretary has made clear, "the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program" is not considered in a "fair hearing" held by a carrier to resolve a grievance related to a determination of the amount of a part B award. As a result, an attach on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an "amount determination" which decides "the amount of the Medicare payment to be made on a particular claim" and with respect to which the Act impliedly denied judicial review.

Michigan Academy, 476 U.S. at 675-76 (citing *Erika* 456 U.S. at 208 (complete citation omitted from original)).

The point was made still clearer by the Court: "[i]n light of Congress' express provision for carrier review of millions of what it characterized as "trivial" claims, it is ***implausible*** to think it intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." *Id.* at 678 (emphasis added).

The Secretary of HHS had argued that the third sentence of Section 405(h) precludes resort to federal question jurisdiction. This Court rejected that argument and labeled it as an extreme position which "we would be most reluctant to adopt without a showing of 'clear and convincing evidence.' " *Id.* at 681.

The Secretary raised the same arguments in the petitioner's case that were unsuccessful in *Michigan Academy*. By doing so, the Secretary continued to block any and all review of the intermediary's refusal to reopen the petitioner's cost reports.

The Sixth Circuit erred when it failed to consider *Michigan Academy* as controlling in petitioner's case. The Sixth Circuit discounted petitioner's reliance upon *Michigan Academy* by shifting the focus to the inconsequential fact that the case concerned Part B benefits. On this basis, the Sixth Circuit found: "[j]urisdictional questions arising under Part B claims are now treated in this circuit identically to such questions arising under Part A, so *Michigan Academy's* amount/methodology distinction no longer has force." *Your Home*, No. 96-5525, 11 n.3, App. 1. It is the petitioner's position that the significance of the ruling in *Michigan Academy* is not acknowledged by the Sixth Circuit. It is a viable decision which still retains its precedential value in the eyes of this Court. In 1991, this Court cited *Michigan Academy* as controlling law when it held that District Court had federal question jurisdiction to hear respondents' constitutional and statutory challenges to the Immigration and Naturalization Service procedures thereby recognizing the continuing force of the decision. *McNary v. Haitian Refugee Center, Inc.*, 498 U.S. 479, 497 (1991).

Counsel for the petitioner asserts the Sixth Circuit failed to appreciate the important principles espoused in the *Michigan Academy* decision. This Court's ruling in *Michigan Academy*, 476 U.S. 667, did not focus upon the different appeal procedures allowed for Part B versus Part A benefits, but rather, concerned itself with the situation in which the problem presented is not even about the amount of the benefit determination. This Court clearly stated the need for judicial review of complaints about regulations, statutes, and constitutional challenges. *Id.* This is the very essence of the subject matter of petitioner's case. Therefore, the petitioner's case is controlled by the holding of the *Michigan Academy* decision and yet, the Sixth Circuit ignored the decision as precedent.' The Sixth Circuit decision now calls into question the continuing validity of that decision. It is crucial for this Court to accept this petition in order to confirm the continuing precedential effect of *Michigan Academy*, a case that is extremely important to all Medicare providers who must voice a complaint about the Secretary's regulations and her interpretations of the Medicare statute. The Sixth Circuit decision deprives petitioner of the right to due process, as guaranteed by the Fifth Amendment to the Constitution of the United States and sets the stage for all Medicare providers within the Sixth Circuit to have their due process rights violated as well.

Disregarding the precedential value of *Michigan Academy* was not the only serious error made by the Sixth Circuit Court. The Sixth Circuit also erred in its statement concerning the need to join the insurance company as an indispensable party. Code of Federal Regulation title 42

section 421.5(b) (1997) provides that intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities and that HCFA is the real party of interest in any litigation involving the administration of the program. The Sixth Circuit implied that the intermediary should have been joined in the suit as an indispensable party, a direct contradiction to the Secretary's own regulation. *Your Home*, No. 96-5525, 9 n.2, App. 1. This statement appears to invite litigation against the insurance companies on an individual basis.

III. The government's position cannot be substantially justified.

Finally, the petitioner would urge this Court to consider the Equal Access to Justice Act, 5 U.S.C. § 504 (West 1996) and 28 U.S.C. § 2412 (West 1996), in regard to this matter. If the petitioner is successful and eventually prevails in this case, the Equal Access to Justice Act would allow an award of attorneys' fees where the position of the United States was not substantially justified. Whether or not the position of the United States was substantially justified should be considered on the basis of the record which is made in the civil action for which fees and other expenses are sought. The test of whether the government's position is substantially justified is one of reasonableness in law and in fact and the United States has the burden of proof with regard to a showing of substantial justification for its position. *Foley Construction Co. v. U.S. Army Corps of Engineers*, 716 F.2d 1202, 1204 (8th Cir. 1983). This standard is said to represent a middle ground between an automatic award of fees and an award only in

circumstances where the government's position was frivolous. H.R. Rep. No. 96-1418, at 14, *reprinted in* 1980 U.S. Code Cong. & Ad. News 4993. The government's position in this case is not substantially justified where there was a secret salary survey discovered that revealed the petitioner's owners should have been paid the owners' compensation they claimed was reasonable. The petitioner's providers had filed administrative appeals related to owners' compensation for 1987, 1990, 1991, 1992, 1993, and 1994. All of these appeals were settled in October 1996 by the intermediary and additional owners' compensation was allowed. (See letters of settlement, App. 55.) The only year which the intermediary has refused to pay additional owners' compensation is the year for which a request to reopen was required because an administrative appeal had not been made. In other words, the intermediary has agreed that the owners were not paid the appropriate amount of owners' compensation for the years of 1987, 1990, 1991, 1992, 1993, and 1994. These cases were settled before the scheduled hearings dates at the Provider Reimbursement Review Board. (In 1988, there were no audit adjustments made to disallow any portion of owners' compensation.) In 1989, the year for which the request for reopenings were made and denied, there was no appeal for Board review requested within the 180 days of receipt of the initial Notice of Program Reimbursement Letters since the owners had not yet discovered the secret salary survey which revealed that competitors were paid more than the petitioner's owners. It was not until after the 180 days elapsed that the petitioner's providers discovered the secret salary survey which was the new and material evidence

that was the basis for the request for reopening of the 1989 cost reports. Because it is so clear that the intermediary is presently aware it paid the incorrect amount of owners' compensation for the petitioners owners for all of the years in question, including the 1989 year, the government's stance of continuing to refuse to reopen the cost reports to correct this error in the 1989 cost reports simply cannot be substantially justified.

It is inherently unfair for an employee of an insurance company to decide that some owners of home health agencies will not be paid as their competitors (who are virtually across the street) are paid. The reason for the discrepancy will never be known where the decision remains unreviewable. The insurance company employee who made this decision not to reopen the 1989 cost reports is not a member of the judiciary, not an elected official, not a lawyer, not a hearing officer. The individual is just a person with a job at an insurance company that has a contract to serve as a Medicare fiscal intermediary.

A person in such a position can be advised of mathematical errors on the settlement of a cost report and still refuse to reopen the cost report to make corrections. Even if the errors were caused by mistakes made by the intermediary, the cost report can still remain unopened. To sum up, no matter what the reason for the denial of reopening, there is no review, no appeal, no remedy, no justice in the Sixth Circuit. This leaves the power of law in the hands of one person working for an insurance company. This individual may not know what the Fifth Amendment to the United States Constitution guarantees. This person may not understand the phrase "due process" and the legal ramifications of that concept. Most

citizens in America expect to receive their day in court. In this situation, the Secretary of HHS and the Sixth Circuit have abolished that right. Instead, an employee of an insurance company will dispense or withhold justice. From this person's decision, there is no appeal. The government's position cannot be justified, and certainly cannot be "substantially justified."

CONCLUSION

The inconsistent treatment of Medicare providers has occurred because of the various interpretations of federal law. These disparities will continue within the districts unless this Court accepts this case and rules upon this issue. Providers in different geographic locations are receiving different measures of justice. The magnitude of the impact of these differences will continue to affect the providers nationwide until this controversy is resolved by one ruling which will govern all Medicare providers. Based upon the arguments and authorities presented herein, the petitioner respectfully requests careful consideration of this matter as appropriate for U.S. Supreme Court review.

Respectfully submitted,

DIANA L. GUSTIN
Counsel of Record
11 Town Square
Post Office Box 1349
Norris, Tennessee 37828
(423) 494-3000
Counsel for Petitioner

APPENDIX A
SIXTH CIRCUIT COURT CASE

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

ELECTRONIC CITATION: 1997 FED App. 0366P (6th Cir.)
File Name: 97a0366p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

YOUR HOME VISITING NURSE SERVICES, INC., *Plaintiff-Appellant,* *v.* SECRETARY OF HEALTH AND HUMAN SERVICES, *Defendant-Appellee.*	))))))))	No. 96-5525

Appeal from the United States District Court
for the Eastern District of Tennessee at Knoxville.
No. 95-00276 – Leon Jordan, District Judge.

Argued: June 5, 1997

Decided and Filed: December 22, 1997

Before: LIVELY, MERRITT, and SUHRHEINRICH, Circuit Judges.

COUNSEL

ARGUED: Diane L. Gustin, Knoxville, Tennessee, for Appellant. Howard H. Lewis, SOCIAL SECURITY ADMINISTRATION, OFFICE OF GENERAL COUNSEL, Atlanta, Georgia, for Appellee. **ON BRIEF:** Diana L. Gustin, Knoxville, Tennessee, for Appellant. Howard H. Lewis, SOCIAL SECURITY ADMINISTRATION, OFFICE

OF GENERAL COUNSEL, Atlanta, Georgia, D. Gregory Weddle, OFFICE OF THE U.S. ATTORNEY, Knoxville, Tennessee, for Appellee.

OPINION

MERRITT, Circuit Judge. We are asked once again to review and construe federal health care statutes and regulations governing reimbursement to a "provider" of services.

The plaintiff, Your Home Visiting Nurse Service, Inc., provides home nursing services to Medicare beneficiaries and receives reimbursement from Medicare. This program is administered by the United States Department of Health and Human Services. As part of the reimbursement procedures, Your Home submits annual cost reports to Blue Cross and Blue Shield of South Carolina, a fiscal intermediary acting as the agent of defendant, the Secretary of Health and Human Service.

Your Home sought to reopen cost reports submitted to Blue Cross for fiscal year 1989 due to findings of "new and material" evidence that the reports should be modified. Blue Cross declined to reopen the cost reports. Your Home then appealed Blue Cross's denial to reopen the cost reports to the Provider Reimbursement Review Board. The Review Board found that it lacked jurisdiction to review a fiscal intermediary's decision not to reopen the plaintiff's 1989 cost reports. Your Home appealed the denial of jurisdiction by the Review Board to the district

court. The district court dismissed the complaint, upholding the Review Board's determination that it lacked jurisdiction and further holding that the district court did not have federal question or mandamus jurisdiction to review directly the fiscal intermediary's decision. A timely appeal to this Court followed. For the reasons set forth below, this Court affirms the judgment of the district court.

This appeal concerns four cost reports that Your Home submitted for the 1989 fiscal year. Blue Cross issued notices of program reimbursement pursuant to 42 C.F.R. § 405.1803 for these cost reports, setting out the reimbursement due and listing the expenses allowed and disallowed. Your Home did not appeal any of the four notices of program reimbursement to the Review Board within the 180-day appeal period specified by statute, 42 U.S.C. § 1395oo. Your Home, however, did file a timely request with Blue Cross to reopen the 1989 cost reports pursuant to 42 C.F.R. § 405.1885 on the ground that Your Home had discovered "new and material evidence" affecting its reimbursement. In particular, Your Home alleged that a prior fiscal intermediary calculated the applicable owner compensation rates incorrectly for the 1987 fiscal year, which then in turn affected the 1989 cost reports.

Your Home raises three issues on appeal: (1) whether the Provider Reimbursement Review Board has jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare cost report; (2) whether the district court has federal question jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare

cost report and (3) whether the district court has mandamus jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare cost report. We will address each of these issues separately below.[1]

1. The Review Board's Jurisdiction

42 U.S.C. § 1395oo(a) states:

> Any provider . . . which has filed a required cost report . . . may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if [in addition to other requirements that are not at issue] (1) such provider (A)(i) is dissatisfied with a final determination of the . . . fiscal intermediary . . . as to the amount of total program reimbursement due the provider. . . .

Your Home's argument turns on whether a fiscal intermediary's denial of a request to reopen is unambiguously a "final determination . . . as to the amount of total program reimbursement due the provider" within the plain meaning of that phrase.

---

[1] On April 3, 1997, Your Home filed a Motion to Request Addition of Document as Exhibit. The "document" is actually two letters purporting to resolve outstanding cases between Blue Cross/Blue Shield and Your Home through an "Administrative resolution." On April 10, 1997, the Secretary filed an objection to Your Home's Motion. Because the documents were not considered by the District Court, we will not consider them here in the first instance. Moreover, the documents do not address the year at issue in this case (1989) and, even if we were to consider the documents filed by Your Home, they would not alter our holding here.

The reopening procedure was created by regulation rather than statute. The Medicaid statute does not require, or even mention, a reopening procedure. Nevertheless, the regulations promulgated by the Secretary specify that a fiscal intermediary's determination "*may* be reopened" (emphasis added) when a request to reopen is made within three years of the determination. 42 C.F.R. § 405.1885(a). The regulations specify, however, that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. § 405.1885(c). The criteria for reopening are set forth in the Provider Reimbursement Manual, which provides:

> Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Provider Reimbursement Manual § 2931.2.

Although the regulations specify that new determinations after a cost report has been reopened are subject to review in the same manner as initial decisions, 42 C.F.R. § 405.1889, the regulations are silent as to whether a decision not to reopen is subject to review. The Provider Reimbursement Manual, however, states: "A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board. . . . " Provider Reimbursement Manual, Appendix A, ¶ B.4.

The Provider Reimbursement Review Board found that it lacked jurisdiction based on the above language in

the Provider Reimbursement Manual. The district court affirmed, construing the Provider Reimbursement Manual language as an interpretive rule pursuant to *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87 (1995), and deferring to the Secretary's interpretation of the Review Board's jurisdiction pursuant to *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). At least two circuit courts have also held that the Review Board does not have jurisdiction over refusals to reopen based on the language in the Manual. *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 85 F.3d 1057 (2d Cir. 1996); *Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1, 4 n.1 (D.C. Cir. 1984); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984) (when fiscal intermediary reopens with respect to some, but not all, issues, Provider Reimbursement Review Board lacks jurisdiction to review partial denial of reopening).

Your Home argues that deference to the Secretary's interpretation in the Manual is inappropriate here because that interpretation is contrary to the plain meaning of the statute. In particular, Your Home argues that a denial of a reopening request is plainly a "final determination" as that phrase is used in the statute. Your Home attempts to bolster this argument by relying on the presumption that administrative actions are subject to judicial review. *See Bowen v. Michigan Academy*, 476 U.S. 667, 670 (1986).

In *Good Samaritan Hospital*, the Second Circuit explained its holding as follows:

> the plain meaning of [42 U.S.C.] § 1395oo(a) does not compel a holding that a reopening denial is a 'final determination' of the amount of total program reimbursement. To the contrary, we believe that the statute may be construed permissibly as stating that a reopening denial is a refusal to revisit the final determination.. . . . [W]hile . . . a decision not to reopen is in some sense 'final,' it does not, in and of itself, establish an amount of total program reimbursement [as required by the statute]. Instead it is a final determination that there are not grounds on which to reconsider a previous final determination as to the amount of total program reimbursement.

Good Samaritan Hosp., 85 F.3d at 1061 (quoting *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 894 F.Supp. 683 (S.D.N.Y. 1995)). In light of this statutory ambiguity, deference to the Secretary's regulations and interpretations is appropriate.

This conclusion is bolstered by the Supreme Court's holding in *Califano v. Sanders*, 430 U.S. 99 (1977). In *Sanders*, an Administrative Law Judge denied a social security disability claimant's request to reopen a claim and the claimant sought judicial review. The claimant argued that the district court had jurisdiction pursuant to section 205(g) of the Social Security Act, which provides: "Any individual, after any final decision of the Secretary made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action commenced within sixty days. . . . " 42 U.S.C. § 405(g). The Supreme Court held that this did not confer jurisdiction because the Social Security Act does not require hearings on petitions to reopen. Moreover, the Court suggested that there would be no federal court jurisdiction even if

the Secretary promulgated regulations allowing for hearings on such petitions:

> [T]he opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act. Moreover, an interpretation that would allow a claimant judicial review simply by filing and being denied a petition to reopen his claim would frustrate the congressional purpose . . . to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits.

Sanders, 430 U.S. at 108.

The Medicare statute, similar to the Social Security Act, does not require the Secretary to afford Medicare providers an opportunity for rehearing of fiscal intermediaries' determinations. Therefore, even if our task in this case were to construe the statute at issue without benefit of the Secretary's interpretation in the Manual, *Sanders* suggests that the proper interpretation would be to avoid frustrating the congressional purpose to impose a 180-day limitation upon Provider Reimbursement Review Board review of a fiscal intermediary's final determination on an initial cost report by holding that the statute does not confer jurisdiction on the Review Board to conduct such a review. The Secretary's interpretation of the Medicare statute in the Manual is reasonable in light of *Sanders*. If that interpretation is not foreclosed by the plain language of the statute, and we find it is not, we must defer to it pursuant to *Chevron*.

Your Home, relying on *Powderly v. Schweiker*, 704 F.2d 1092 (9th Cir. 1983), argues that this Court should not defer to the Secretary's interpretation in the Provider Reimbursement Manual because that interpretation is a substantive rule and substantive rules must be promulgated in accordance with the Administrative Procedure Act's notice and comment period requirements, which was not done here. The rule in question, however, is an interpretive rule and the Administrative Procedure Act exempts interpretive rules from its notice and comment requirements. 5 U.S.C. § 553(b)-(c). As the *Powderly* court explained, "[s]ubstantive rules are those which effect a change in existing law or policy. Interpretive rules are those which merely clarify or explain existing law or regulations." *Powderly*, 704 F.2d at 1098. As in *Powderly*, the Manual provision at issue here does not change any existing law or policy and does not remove any previously existing rights of Medicare providers. It merely explains "what the more general terms of the Act and regulations already provide." *Id*. The Manual merely provides an interpretive rule. As the Supreme Court recently held, such agency interpretive rules are subject to deference when they are not contrary to statute. *See Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87 (1995).

Your Home's reliance on the presumption that federal courts have jurisdiction to review administrative decisions is also unavailing. Although the *Sanders* Court did not address that presumption explicitly, the *Sanders* decision suggests that the presumption does not apply to administrative proceedings not required by statute that expand a claimant's opportunity for administrative

review beyond statutory requirements that, in themselves, provide adequate opportunities for judicial review. Your Home could have obtained judicial review of the fiscal intermediary's final decision on its initial claim by filing an appeal with the Review Board within 180 days of that decision and continuing with further appeals, if necessary, as provided in the Medicare statute. Those statutory procedures are adequate to preserve judicial review. As in *Sanders*, the Secretary is entitled to create a reopening procedure to provide even greater protection to providers than required by statute without having to incur the additional expense entailed by full administrative and judicial review of refusals of requests to reopen.

2. Federal Question Jurisdiction

Your Home argues that even if the Provider Reimbursement Review Board lacked jurisdiction to consider Your Home's appeal, the district court had either federal question jurisdiction or mandamus jurisdiction to review directly the fiscal intermediary's refusal to reopen. Your Home therefore requested as relief an order directing the fiscal intermediary, Blue Cross, to reopen the cost reports at issue.[2]

---

[2] We note that, despite this request for relief, Your Home failed to join Blue Cross in the suit. Although not addressed by the court below, this may constitute a failure to join an indispensable party. If that is so, the district court could have ordered that Blue Cross be joined as a party or, if that was not possible, dismissed the suit on that basis. Fed. R. Civ. P. 19. Because neither the district court nor the Secretary raised the failure to join an indispensable party, we will not base our holding on that issue.

The applicable regulations limit judicial review of the Secretary's decisions. 42 U.S.C. § 1395ii provides:

> [t]he provisions of . . . subsection[ ] . . . (h) . . . of section 405 of this title, shall also apply with respect to this subchapter . . . except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

42 U.S.C. § 405(h) provides:

> No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Your Home argues that "claim" as used in § 405(h) is a term of art referring to a Medicare claim for reimbursement and that collateral challenges not requiring consideration of the merits are outside the scope of the statute.

Your Home's argument is foreclosed by *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the Secretary of Health and Human Services issued an administrative ruling that Medicare did not cover a certain surgical procedure. Four individual claimants brought a suit challenging the ruling, asserting federal question jurisdiction. The Court held that § 405(h) barred the suit, finding that "the inquiry in determining whether § 405(h) bars

federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Id.* at 614-15. The proper test is whether " 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare statute. *Id.* at 615 (quoting *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975)). *See also Califano v. Sanders*, 430 U.S. 99 (1977) (§ 405(h) precludes federal question jurisdiction).

Here both the standing and the substantive basis for the presentation of Your Home's claims comes from the plain language of the Medicare statute. Therefore § 405(h) precludes federal question jurisdiction.[3]

3. Mandamus Jurisdiction

Finally, Your Home argues that the district court had mandamus jurisdiction to review Blue Cross' failure to reopen. Section 405(h) explicitly precludes jurisdiction pursuant to 28 U.S.C. §§ 1331 & 1346, but does not mention the mandamus statute, 28 U.S.C. § 1361. The Supreme Court has explicitly left open the question of whether or not § 405(h) precludes mandamus jurisdiction. *See, e.g., Califano v. Yamasaki*, 442 U.S. 682 (1979). Several

[3] Your Home's reliance on *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), is unavailing. *Michigan Academy* concerned a Part B Medicare provider. Jurisdictional questions arising from Part B claims are now treated in this Circuit identically to such questions arising under Part A, so *Michigan Academy's* amount/methodology distinction no longer has force. *Farkas v. Blue Cross & Blue Shield*, 24 F.3d 853, 860 (6th Cir. 1994).

courts, however, have held that mandamus jurisdiction exists over challenges to the Secretary's procedural rules. *See Ellis v. Blum*, 643 F.2d 68, 78 (2d Cir. 1981); *Frost v. Weinberger*, 515 F.2d 57, 62 (2d Cir. 1975); *Knuckles v. Weinberger*, 511 F.2d 1221, 1222 (9th Cir. 1975); *Martinez v. Richardson*, 472 F.2d 1121, 1125-26 (10th Cir. 1973).

Mandamus jurisdiction is available only if (1) the plaintiff has exhausted all available administrative appeals and (2) the defendant owes the plaintiff a "clear nondiscretionary duty" that it has failed to perform. *Heckler v. Ringer*, 466 U.S. 602, 616. The district court found that Your Home failed to exhaust administrative appeals because it failed to appeal Blue Cross' initial decision within 180 days, not the decision not to reopen the cost reports. The district court also held that there was no violation of a clear non-discretionary duty because the Secretary has discretion over the decision whether or not to reopen a cost report based on "new and material evidence."

The district court's holding with respect to exhaustion is incorrect. Your Home's failure to appeal the initial determination would preclude mandamus review of that determination, but does not preclude review of a decision not to reopen. Your Home has exhausted all available remedies with respect to its claim that Blue Cross improperly denied its request to reopen.

With respect to the existence of a nondiscretionary duty, the relevant regulation states:

> A determination of an intermediary . . . *may* be reopened . . . by such intermediary officer . . . on

> motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

42 C.F.R. § 405.1885(a) (emphasis added). In addition, the Provider Reimbursement Manual provides:

> Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether (1) new and material evidence has been submitted, (2) a clear and obvious error was made, or (3) the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Provider Reimbursement Manual § 2931.2.

In *Good Samaritan Hospital Regional Medical Center v. Shalala*, 894 F.Supp. 683 (S.D.N.Y. 1995), *aff'd on other grounds*, 85 F.3d 1057 (2d Cir. 1996), the court, after reviewing these provisions, concluded that the fiscal intermediary's reopening determination is discretionary because the regulation says only that the fiscal intermediary "may" reopen, and the manual merely lists the factors that must be considered, without specifying that reopening must be granted if those factors are present.

The district court looked to the Secretary in determining the existence of a nondiscretionary duty. The district court looked to the wrong party under the language in the regulation. Although the Secretary has discretion over whether to allow reopenings, the proper question is whether Blue Cross, the fiscal intermediary, had a nondiscretionary duty to reopen pursuant to the Secretary's regulations and interpretations thereof. As noted above, Blue Cross was not a party to this action. However, even if Blue Cross had been joined as a party, its decision not

to reopen was discretionary based on *Good Samaritan Hospital* and would not have triggered mandamus jurisdiction. Therefore, the district court properly found that it did not have mandamus jurisdiction, even though its analysis was incorrect.

For the foregoing reasons, we AFFIRM the judgment of the district court.

APPENDIX B
DISTRICT COURT DECISION

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
TENNESSEE AT KNOXVILLE

YOUR HOME VISITING NURSE SERVICES, INC., Plaintiff,	)	No. 3:95-cv-276 (Filed Mar. 22, 1996)
v.	)	
SECRETARY OF HEALTH AND HUMAN SERVICES, Defendant.	)	

ORDER

For the reasons stated in the Memorandum Opinion filed contemporaneously with this Order, it is hereby ORDERED that the defendant's motion to dismiss or, in the alternative, for summary judgment [doc. 5] is GRANTED, and all claims against the defendant are DISMISSED.

ENTER:

/s/ Leon Jordan
Leon Jordan
United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF TENNESSEE
AT KNOXVILLE

YOUR HOME VISITING NURSE SERVICES, INC.,	)	
Plaintiff,	)	
	)	No. 3:95-cv-276
v.	)	
SECRETARY OF HEALTH AND HUMAN SERVICES,	)	(Filed March 22, 1996)
Defendant.	)	

MEMORANDUM OPINION

This civil matter is before the court on the defendant's motion to dismiss or in the alternative for summary judgment [docs. 5 and 6]. The plaintiff has responded [doc. 7], and the defendant has replied [doc. 9]. Oral argument was heard on the defendant's motion and thus, the motion is ripe for the court's consideration. For the reasons stated below, the court finds the defendant's motion well-taken, and the complaint must be dismissed.

The issue in this case arising under the Medicare statute is whether the refusal of a fiscal intermediary to reopen a Medicare service provider's cost report is administratively or judicially reviewable. The Sixth Circuit Court of Appeals has not addressed this issue, and there is a split of opinion among the other circuit courts of appeal.

The plaintiff in this case is a service provider under the Medicare program. The complaint seeks a review of

the determination by the Provider Reimbursement Review Board (PRRB) that it had no jurisdiction to reconsider the decision of the fiscal intermediary, Blue Cross and Blue Shield of South Carolina (BCBS/SC), to not reopen the plaintiff's 1989 cost report. The plaintiff asks this court to reverse the PRRB's decision that it had no jurisdiction and either remand the case back to the PRRB so it can review BCBS/SC's decision not to reopen the cost report or to make a finding that BCBS/SC erred in not reopening the cost report. In its response to the defendant's motion, the plaintiff has withdrawn its request that the court determine the amount of compensation due the plaintiff and concedes that this is a decision for BCBS/SC to make.

I. BACKGROUND

A. Relevant Statutes and Regulations

The Medicare program was established by Congress to provide a system of health insurance for the aged and disabled. 42 U.S.C. § 1395 *et seq.* The program is divided into two parts: Part A which provides insurance for inpatient institutional services, home health services and post-hospital services, 42 U.S.C. §§ 1395c and 1395d; and Part B which covers physician, outpatient hospital, and other health services, 42 U.S.C. §§ 1395j, 1395*l* and 1395x. Home health care agencies (providers), such as the plaintiff in this case, participate in the Medicare program by entering into provider agreements with the Secretary. 42 U.S.C. § 1395h. Under these agreements, the provider agrees to provide Medicare beneficiaries with services

and seek reimbursement from private insurance companies (fiscal intermediaries) who act as agents of the Secretary.

At the end of a provider's fiscal year, the provider is required to file a cost report with the fiscal intermediary. 42 C.F.R. § 413.20(b). The fiscal intermediary analyzes the cost report and furnishes the provider with a notice of program reimbursement (NPR) which sets out the reimbursement due the provider and lists the expenses allowed and disallowed. 42 C.F.R. § 405.1803.

The NPR also advises the provider of its appeal rights. *Id.* If the provider is dissatisfied with the NPR and the amount in controversy is $10,000 or more, it may request a hearing before the PRRB within 180 days of the issuance of the NPR. 42 U.S.C. § 1395oo. The PRRB may affirm, modify or reverse the decision of the fiscal intermediary. *Id.* The Secretary may then review the PRRB decision within sixty days. If the provider is still dissatisfied, then the provider may seek judicial review in the United States district court within sixty days of the final decision. *Id.*

If the provider does not appeal the final cost report determination within 180 days, the cost report is closed and the amount of reimbursement is not subject to further review. However, the Medicare regulations permit one exception to this timetable; that is, the Secretary or the provider may seek to have the fiscal intermediary reopen the cost report within three years of the fiscal intermediary's decision. (The three-year limitation may be waived if the decision "was procured by fraud or

similar fault of any party.") 42 C.F.R. § 405.1885. Reopenings require a showing that there is new and material evidence to be submitted, that clear or obvious error was made, or the original decision was inconsistent with the law. Provider Reimbursement Manual (PRM) (HIM-15) § 2931.2. Neither the Medicare regulations nor the PRM provide a mechanism for appealing a denial of a reopening request, and it is this lack of authorization for an appeal which creates the issue in this case.

B. Procedural History

On March 29, 1991, BCBS/SC issued four NPR's to the plaintiff's four agencies for the fiscal year 1989. Each NPR informed the plaintiff that it had 180 days to appeal the determination of BCBS/SC. The plaintiff did not file administrative appeals with PRRB within 180 days. During the course of appealing later NPR's, the plaintiff discovered that BCBS/SC had set a base rate for the plaintiff's owner compensation by comparing plaintiff's owner compensation rate to individual agencies rather than chain operations such as plaintiff's. The plaintiff alleges that this resulted in a base salary rate which was much lower than its owners were entitled.

Upon discovery of this information, the plaintiff sought to have BCBS/SC reopen the cost reports for fiscal year 1989, claiming that it had new and material evidence to submit for the intermediary's consideration. BCBS/SC declined to reopen the cost reports and the plaintiff attempted to appeal this decision with the PRRB. The PRRB determined that it did not have jurisdiction over a decision not to reopen a cost report because a decision

not to reopen a cost report is not a "final determination" within the meaning of the statute and regulations. The plaintiff then filed this action asking this court to review the PRRB's decision.

II. DISCUSSION

A. Standard of Review

Pursuant to 42 U.S.C. § 1395oo(f)(1), a decision by the PRRB is subject to review in accordance with the Administrative Procedures Act (Chapter 7 of Title 5, United States Code). A court may set aside a final agency action only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A); *see also, Thomas Jefferson Univ. v. Shalala*, ___ U.S. ___, 114 S.Ct. 2381, 2386, 129 L.Ed.2d 405 (1994). This standard of review is considered to be "highly deferential." *See Binghamton Gen. Hosp. v. Shalala*, 856 F. Supp. 786, 792 (S.D.N.Y. 1994). A court should give substantial deference to an agency's construction of a statutory scheme it is entrusted to administer. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984); *Binghamton*, 856 F. Supp. at 792.

Where Congress has expressly authorized an agency to promulgate regulations, as it has with the Medicare scheme, "[s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron*, 467 U.S. at 844, 104 S.Ct. at 2782. Further, an agency's interpretation of its regulations is entitled to great deference unless the interpretation is plainly erroneous or inconsistent with the

underlying regulation or statute. *See Thomas Jefferson Univ.*, 114 S.Ct. at 2386. This is especially true when the regulations concern "a complex and highly technical regulatory program" such as the Medicare program. *Id.* at 2387 (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)).

In its motion to dismiss or for summary judgment, the defendant argues that, under Sixth Circuit law, this court's review is limited to whether the PRRB erred in determining that it lacked jurisdiction. *Saline Community Hosp. v. Secretary of Health and Human Services*, 744 F.2d 517 (6th Cir. 1984). In *Saline*, the plaintiffs attempted to amend their cost reports to include an additional amount for reimbursement after the deadline for filing their cost reports. *Id.* at 518. The fiscal intermediaries rejected the proposed amendments because the amendments did not "revise" the cost report information previously submitted.[1] The PRRB declined to hear the plaintiffs' appeals because it determined that its jurisdiction was limited to a review of the fiscal intermediary's determination on the cost reports and matters covered therein. *Id.* at 519. Since the cost reports did not have the proposed amendments, the PRRB declined jurisdiction. *Id.* The Sixth Circuit stated that the PRRB "properly refused the requests for hearings." *Id.* The court found that the PRRB's finding of no jurisdiction was a final decision subject to judicial review, but judicial review was limited to that issue

---

[1] The regulation provides: "Amended cost reports to revise cost report information which has been previously submitted may be permitted or required as determined by the Health Care Financing Administration." 42 C.F.R. § 405.435(f).

alone. "The district court could not rule on the *merits* of the claim over which the Board declared it lacked jurisdiction, only on whether the Board's jurisdictional decision was correct." *Id.* at 520 (emphasis in original).

In its response, the plaintiff appears to agree that this is the correct "scope of review" for this court, and avers that it "does not ask this Court to rule upon the merits of the claim. If this court finds the Board was incorrect in the decision that it lacked jurisdiction, the case should be remanded back to the Board." *See* doc. 7, at p. 5. However, the plaintiff then states:

> In the alternative, the plaintiff asked this Court to make its own finding that the intermediary abused its discretion in refusing to re-open the 1989 cost report and to order the intermediary to re-open the cost report to review the new and material evidence concerning the previous intermediary's use of a salary survey for owners' compensation which was not comparable to the owners of the plaintiff's chain operation. . . .

Doc. 7, at pp. 5-6. The plaintiff argues that this request is not for a ruling on the merits.

The court disagrees. Any finding that this court might make concerning whether the intermediary abused its discretion in failing to reopen the 1989 cost report would be, in fact, a ruling on the merits of the claim since this court would have to decide whether the plaintiff's evidence was new and material. The PRRB determined that it did not have jurisdiction over BCBS/SC's decision not to reopen, and under *Saline*, this court's review is limited to a review of the PRRB's determination. *See also Binghamton*, 856 F. Supp. at 793.

B. Review of the PRRB's Decision

In her motion to dismiss or for summary judgment, the Secretary argues that the PRRB's decision that it did not have jurisdiction was correct. The Secretary submits that her agency's regulations and the Provider Reimbursement Manual support this view.

Section 1395oo(a) of Title 42, United States Code, provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider –
>
> (a)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . .
>
> . . . .
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider filed a request for a hearing within 180 days after notice of the intermediary's final determination. . . .

Thus, the question for this court is whether a decision by the fiscal intermediary not to reopen is a final determination since the PRRB only has jurisdiction over final determinations. It must be noted again that the statute does not address reopening procedures; the reopening procedures are found only in the implementing regulations. The regulations state that a provider affected by a determination of the intermediary, the

PRRB, or the Secretary may move to reopen the determination or decision to revise any matter in issue. 42 C.F.R. § 405.1885(a). The regulations provide that when an intermediary decision is reopened *and revised*, the revision will be considered to be an appealable final determination. But, subpart (c) provides: "Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 U.S.C. § 405.1885(c).

The Secretary has expressed her interpretation of this portion of the regulations in the Provider Reimbursement Manual. Appendix A to the PRM states at paragraph 4:

> *Refusal to Reopen.* – A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 CFR § 405.1885(c), except for providers which are located within the jurisdiction of the U.S. Ninth Circuit Court of Appeals, where such refusal to reopen is appealable. . . . "

As pointed out by the defendant, the Supreme Court recently has indicated that manual provisions are an appropriate means for the Secretary to express her interpretation of the regulations. *See Shalala v. Guernsey Memorial Hospital*, ___ U.S. ___, 115 S.Ct. 1232, 131 L.Ed.2d 106 (1995).

The plaintiff argues that the regulation cited above is a substantive rule which was not promulgated in accordance with the notice and comment period required by the APA and, therefore, should not be enforced. In her reply brief, the defendant submits that "[i]t is hard to imagine a better example of an interpretive rule than § 2932.1 which simply rephrases a regulation, 42 C.F.R.

§ 405.1885(c). The court agrees. The manual rules are clearly interpretive of the regulations and given to providers to help them comply with the Secretary's regulations.

The Sixth Circuit has not addressed whether the intermediary's decision not to reopen a cost report is a final determination subject to appeal to the PRRB, and there is a difference of opinion among the other circuits. For example, the Circuit Court of Appeals for the District of Columbia has held that 42 C.F.R. § 405.1885(c) makes denials of reopenings unappealable. *See, e.g., St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447, 1449 (D.C. Cir. 1984). The District Court for the Southern District of New York has come to this same conclusion. *See Good Samaritan Hosp. Regional Medical Ctr. v. Shalala*, 894 F. Supp. 683, 695 (S.D.N.Y. 1995); *Binghamton*, 856 F. Supp. at 799. To the contrary, the Ninth Circuit Court of Appeals has found that the PRRB could review a refusal by the intermediary to reopen a cost report.[2] *See State of Oregon v. Bowen*, 854 F.2d 346, 349-40 (9th Cir. 1988).

Obviously, the plaintiff urges this court to follow the Ninth Circuit. However, this court finds that the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute.

The court finds the District Court's opinion in *Binghamton* very beneficial. In *Binghamton*, the issue before the

---

[2] This result is reflected in the language of the PRM quoted above.

District Court for the Southern District of New York was nearly identical to the issue here: whether the PRRB had jurisdiction to review a decision by the fiscal intermediary not to reopen cost reports and allow evidence of reimbursement for malpractice insurance. The court undertook a careful review of the statutes, regulations and the manual provisions and determined that the PRRB was correct in its determination that it did not have jurisdiction to review reopening decisions. *Binghamton*, 856 F. Supp. at 799.

The court first determined that a decision not to reopen is not a final determination within the meaning of the statute (42 U.S.C. § 1395oo). *Id.* at 795. The court recognized that the statute is ambiguous but decided that the most reasonable interpretation is that denials of reopening are not appealable final determinations. The court reasoned that an intermediary's decision not to reopen a cost report is "basically a decision not to disturb its previous decision. As such, it is akin to the decision of a judicial panel or en banc court to deny rehearing, and 'no one supposes that that denial, as opposed to the panel opinion, is an appealable action.' " *Id.* at 794 (quoting *ICC v. Brotherhood of Locomotive Engineers*, 482 U.S. 270, 280, 107 S.Ct. 2360, 2366, 96 L.Ed.2d 222 (1987)).

Since the *Binghamton* court determined that the statute was ambiguous, the court looked next to the Secretary's reopening regulations. *Binghamton*, 856 F. Supp. at 796. The court discussed 42 C.F.R. § 405.1885(c) (quoted above) and stated:

> To the extent that there is any ambiguity in § 405.1885(c)'s assertion that jurisdiction for reopening "rests exclusively" with the reopening agency, this is put to rest in the manual, which expressly precludes review of intermediaries' decisions denying reopening. . . . The Secretary's interpretation of the regulations as set forth in the PRM is entitled to deference.

Id. at 797.

Finally, the court looked at the Ninth Circuit case which has come to the opposite conclusion and found that the decision was flawed in several respects. First, the court noted that the Ninth Circuit failed to consider the policies and procedures set by the Secretary in the PRM. *Id.* Second, the court noted that the Ninth Circuit failed to read § 405.1885(c) in context with the other reopening regulations, specifically, there is no regulation authorizing review of reopening denials comparable to § 405.1889 which provides for review of *revised* cost reports after reopening. *Id.* at 798. The court stated that this demonstrates a decision by the Secretary to make reopening denials unreviewable. *Id.* Finally, the *Binghamton* court found the Ninth Circuit's policy reasons unpersuasive. The Ninth Circuit found that there must be judicial review of reopening denials under the general presumption that agency action should be reviewable. *See State of Oregon*, 854 F.2d at 350. However, the *Binghamton* court recognized that the Supreme Court rejected a challenge to a reopening denial in the context of the Social Security program. *See Califano v. Sanders*, 430 U.S. 99, 104, 97 S.Ct. 980, 984, 51 L.Ed.2d 192 (1977).

In *Sanders*, the Supreme Court was called upon to decide if judicial review was available after the Secretary (of Health, Education and Welfare) declined to reopen a

claim for benefits under the Social Security Act.[3] Like the statutory and regulatory scheme for Medicare, only the Social Security regulations provided for a reopening mechanism. The Court recognized that "judicial review should be widely available to challenge the actions of federal administrative officials." *Sanders*, 430 U.S. at 104, 97 S.Ct. at 984. However, the Court went on to hold that section 405(g) of Title 42, United States Code, clearly limited judicial review to "final decisions." *Id.* 430 U.S. at 108, 97 S.Ct. at 986. The Court stated: "[A]n interpretation that would allow a claimant judicial review simply by filing – and being denied – a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [§ 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Id.*

The *Binghamton* court concluded by holding that the "Secretary's determination, in the Medicare regulations and the Provider Reimbursement Manual, that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Binghamton*, 856 F. Supp. at 799. This court agrees and finds that the PRRB's decision that it lacked jurisdiction was correct. The defendant's motion to dismiss or for summary judgment on this issue must be granted.

---

[3] *See Rhode Island Hosp. v. Califano*, 585 F.2d 1153 (1st Cir. 1978) (finding that 42 U.S.C. 405(g) is the "functional equivalent" of section 1395oo).

C. Plaintiff's Alternate Bases for Jurisdiction

The plaintiff also claims that this court has federal question and mandamus jurisdiction. The defendant argues that federal question jurisdiction has been statutorily rejected and mandamus relief is not available because the plaintiff cannot demonstrate that it exhausted all avenues of relief or that the Secretary owes it a non-discretionary duty.

First, on the issue of federal question jurisdiction (28 U.S.C. § 1331), the applicable statute is 42 U.S.C. § 1395ii. That statute specifically incorporates § 405(h) of Title 42 into the Medicare program statutes. Section 405(h) provides:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28, United States Code, to recover on any claim arising under this subchapter.

The defendant argues that since the plaintiff's claim is brought under the Medicare Act, this statute precludes federal question jurisdiction. *See Heckler v. Ringer*, 466 U.S. 602, 614, 104 S.Ct. 2013, 2021, 80 L.Ed.2d 622 (1984). If, as the defendant argues, the plaintiff's claim arises under the Medicare Act, then the plaintiff's only avenue to judicial review is found at 42 U.S.C. § 1395oo. The defendant argues that since the plaintiff did not avail

itself of the remedies available under § 1395oo, the plaintiff cannot rely on federal question jurisdiction.

The plaintiff attempts to distinguish its claim as one for which federal question jurisdiction might lie. Relying upon *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986), the plaintiff argues that since it is not seeking review of the reimbursement claim itself, this court has federal question jurisdiction over the reopening denial. However, in *Michigan Academy,* the plaintiffs were challenging the validity of a regulation. The Supreme Court stated that this type of action was not a claim arising out of the Medicare Act; in other words, the plaintiffs were not seeking to have a claim adjudicated.

This is not the situation in the present case. Ultimately, the plaintiff is seeking review of its claim for increased owners' compensation, although there were some procedural hurdles along the way. As the Supreme Court in *Ringer* noted, even though the plaintiff complains about the Secretary's procedures, that complaint is "inextricably intertwined" with the plaintiff's claim for increased owners' compensation. *Ringer,* 466 U.S. at 614, 104 S.Ct. at 2021. "[T]o be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Id.* at 615, 104 S.Ct. at 2021.

The court finds that the plaintiff's claim "arises under" the Medicare Act, since it is, at bottom, a claim for increased compensation. *See Good Samaritan Hosp.*

Regional Medical Ctr. v. Shalala, 894 F. Supp. 683, 695 (S.D.N.Y. 1995) (considering a nearly identical issue and finding that the claims arise under the Medicare statute). The court finds that federal question jurisdiction is not available to the plaintiff.

Next, in its complaint the plaintiff also suggests that this court has mandamus jurisdiction (28 U.S.C. § 1361). The defendant argues that this court does not have mandamus jurisdiction either because the plaintiff has not exhausted all avenues of relief (the plaintiff failed to appeal the NPR within 180 days) and the plaintiff cannot show that the defendant owes the plaintiff a clear, nondiscretionary duty (whether to reopen to reopen [sic] the cost report to consider the plaintiffs' "new and material" evidence is matter within the discretion of the Secretary). *See Ringer,* 466 U.S. at 616-17, 104 S.Ct. at 2022-23; *Good Samaritan,* 894 F. Supp. at 695-96. The plaintiff has not responded to this portion of the defendant's argument.

The court finds the defendant's argument that this court does not have mandamus jurisdiction well-taken, and the plaintiff's jurisdictional claim on this basis must be denied.

III. CONCLUSION

For the reasons stated above, the defendant's motion to dismiss or for summary judgment is granted and the plaintiff's claims are dismissed.

ENTER:

/s/ Leon Jordan
Leon Jordan
United States District Judge

APPENDIX B
PROVIDER REIMBURSEMENT REVIEW BOARD
DISMISSAL OF CASE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

Jan. 10, 1995

REFER TO 95-0006G
CERTIFIED MAIL

Location Professional Bldg
Room 104

Diana L. Gustin, Esq.
London & Amburn
1716 Clinch Avenue
Knoxville, TN 37916

Dear Ms. Gustin:

RE: Your Home Visiting Nurse Services, Inc., Denial of the Reopening Group Appeal, Provider Nos. 44-H003, 44-7100, 44-7234, 44-7304, FYE 12/31/89, PRRB Case No. 95-0006G

The Provider Reimbursement Review Board (Board) has reviewed the documentation submitted in the above captioned case. The decision of the Board is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 and .1841, a provider has a right to hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the threshold amount of $50,000 required for Board jurisdiction over a group appeal has been met, and the request for hearing is filed within 180 days of the date of the final determination.

In this case, the Provider filed an appeal within 180 days from the date of the refusal of the Intermediary to reopen the cost report; but more than 180 days after the Notice of

Program Reimbursement (NPR) had been issued. The Board finds that it does not have jurisdiction over the Intermediary's refusal to reopen the cost report. The Board holds that 42 C.F.R. § 405.1885(c) governs the review of a denial to reopen a cost report. Section 405.1885(c) states that jurisdiction for reopening a determination rests exclusively with the administrative body that rendered the last determination. Since the Intermediary was the administrative body that rendered the last determination, it is the Intermediary's decision whether or not to reopen the cost report.

Consequently, the Board finds that it does not have jurisdiction over this appeal and hereby dismisses this case. This determination is subject to the provisions of 42 U.S.C. § 1395(f) and 42 C.F.R. § 405.1875 and .1877.

FOR THE BOARD:

/s/ Charles E. Tyler
Charles E. Tyler
Board Member

Enclosures: 42 U.S.C. § 1395(f), 42 C.F.R. §§ 405.1875 and .1877

cc: Bessie T. Wheeler, BC/BS of South Carolina
Wilson Leong, BCBSA

APPENDIX B
INTERMEDIARY REFUSAL TO REOPEN

Medicare

Audit and Reimbursement
Post Office Box 100190
Columbia, South Carolina 29202

April 21, 1994

Ms. Diana L. Gustin
London & Amburn, P.C.
1716 Clinch Avenue
Knoxville, Tennessee 37916

Re: Your Home Visiting Nurse Service, Inc.
Provider No: 4407100, 44-7300, 44-7234, 44-7304
FYE: December 31, 1989

Dear Ms. Gustin:

I am writing in response to your letter of March 28, 1994, which was addressed to Bruce Hughes. In this letter, you requested a reopening of the 1989 cost reports of Your Home Visiting Nurse Service, Inc., to increase the amount of owners' compensation. The compensation contained on the settled cost reports is the amount that was initially claimed when the cost reports were filed.

A request for reopening can be granted for several reasons. These reasons, as stated in Section 2931.2 of HCFA Publication 15-1, are:

> new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Your request for reopening is denied. The manner in which the home office cost statement was filed was not

inconsistent with the law, regulations and rulings or general instructions. A clear and obvious error was not made when these cost reports were filed. And, new and material evidence has not been presented to establish that the compensation claimed was inappropriate.

If you have any questions, you may contact me at (803) 788-0222, extension 1252.

Sincerely,

/s/ Jim Peebles
Jim Peebles
Audit Manager
Medicare Audit and Reimbursement

cc: Bruce Hughes, Medicare Administration
Sharon Roberts, Medicare Audit and Reimbursement
Bessie Wheeler, Medicare Audit and Reimbursement
Pat Anderson, Medicare Audit and Reimbursement

APPENDIX C
COURT OF APPEALS JUDGMENT ISSUED AS MANDATE

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No: 96-5525

YOUR HOME VISITING NURSE SERVICES, INC.,
Plaintiff-Appellant,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellee.

Before: **Lively, Merritt,** and **Suhrheinrich,** Circuit Judges.

JUDGMENT

(Filed Dec. 22, 1997)

ON APPEAL from the United States District Court for the Eastern District of Tennessee at Knoxville.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
Leonard Green, Clerk

Issued as Mandate: February 20, 1998 A True Copy.

COSTS: NONE Attest:

Filing Fee .....$ /s/ Patricia J. Elder
Printing .....$ Deputy Clerk

Total .....$

APPENDIX D
STATUTES, CONSTITUTIONAL PROVISIONS, AND REGULATIONS

I. STATUTORY PROVISIONS

5 U.S.C. § 504 (West 1996) – Equal Access to Justice Act: Costs and Fees of Parties

(a)(1) An agency that conducts an adversary adjudication shall award, to a prevailing party other than the United States, fees and other expenses incurred by that party in connection with that proceeding, unless the adjudicative officer of the agency finds that the position of the agency was substantially justified or that special circumstances make an award unjust. Whether or not the position of the agency was substantially justified shall be determined on the basis of the administrative record, as a whole, which is made in the adversary adjudication for which fees and other expenses are sought

5 U.S.C. § 706 (West 1996) – Administrative Procedure Act: Scope of Review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall –

1) compel agency action unlawfully withheld or unreasonably delayed; and

2) hold unlawful and set aside agency action, findings, and conclusions found to be –

   A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

   B) contrary to constitutional right, power, privilege, or immunity;

C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

D) without observance of procedure required by law;

E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

28 U.S.C. § 1254 (West 1993) Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

28 U.S.C. § 1331 (West 1996) – Federal Question Jurisdiction

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1361 (West 1996) – Mandamus

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

28 U.S.C. § 2412 (West 1996) – Equal Access to Justice Act

(b) Unless expressly prohibited by statute, a court may award reasonable fees and expenses of attorneys, in addition to the costs which may be awarded pursuant to subsection (a), to the prevailing party in any civil action brought by or against the United States or any agency or any official of the United States acting in his or her official capacity in any court having jurisdiction of such action. The United States shall be liable for such fees and expenses to the same extent that any other party would be liable under the common law or under the terms of any statute which specifically provides for such an award.

42 U.S.C. § 405(h) (West Supp. 1997) – Commissioner's Decision Binding

(h) The findings and decisions of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such a hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code, to recover on any claim arising under this title.

42 U.S.C. § 1395x(v)(1)(A) (West Supp. 1997) – Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations

(which have developed such principles) in computing the amount of payment, to be made by persons other than recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395oo (West Supp. 1996) – Provider Reimbursement Review Board: Jurisdiction

a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such subsection may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) or section 1886,

(B) has not received such final determination from such intermediary of a timely basis after filing such report where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

d) A decision by the Board shall be based upon the record made at such hearing, which shall include the

evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provision of subsections (d) and (e) of section 205 with respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

f) (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a

question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determinations in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing

under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

g)(1) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items and services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1886(d)(7) shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members

shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

i) The Board is authorized to engage in such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

j) In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

II. CONSTITUTIONAL PROVISIONS

U.S. Const. amend. V.

No person shall be held to answer for a capital or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb, nor shall be compelled in any criminal case to

be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

III. REGULATIONS

42 C.F.R. § 405.1885 (1997) – Reopening a determination or decision

a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, or by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officers or panel of hearing officers, Board, Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or, where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is

inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault or any party to the determination or decision.

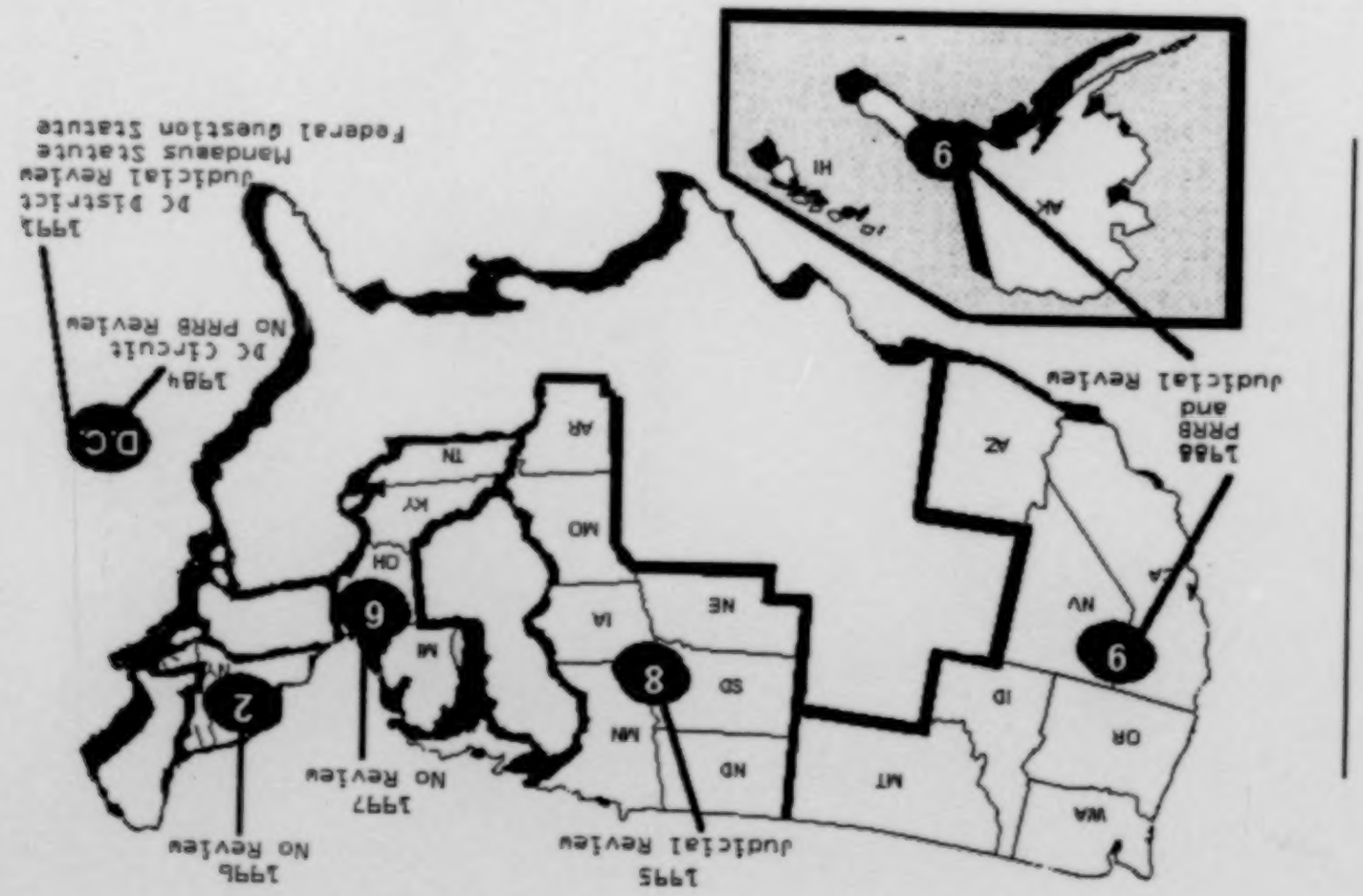
e) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c)). However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of the regulations which, prior to the publication of the Subpart R, governed the reopening of such determinations).

42 C.F.R. § 421.5(b) (1997) – Intermediaries and Carriers: General Provisions

(b) Indemnification of intermediaries and carriers. Intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts

contain clauses providing for indemnification with respect to actions taken on behalf of HCFA and HCFA is the real party of interest in any litigation involving the administration of the program.

APPENDIX E
MAP OF JURISDICTIONS


1992
DC District
Judicial Review
Mandamus Statute
Federal Question Statute
D.C.
1984
DC Circuit
No PRRB Review
1984
PRRB
and
Judicial Review
9
AK
HI
9
AZ
NV
8
ND
SD
NE
MT
WY
CO
UT
6
MI
OH
IN
IL
WI
MN
IA
MO
KS
KY
TN
AR
LA
MS
AL
GA
FL
SC
NC
VA
WV
PA
NY
VT
NH
ME
MA
RI
CT
NJ
DE
MD
2
1995
Judicial Review
1997
No Review
1996
No Review

APPENDIX E
SETTLEMENT

FILE COPY

DIANA L. GUSTIN
ATTORNEY AT LAW

FIRST TENNESSEE PLAZA, SUITE 2001
• 800 SOUTH GAY STREET
• KNOXVILLE, TENNESSEE 37929
TELEPHONE (423) 523-5545 • TELECOPIER (423) 523-4738

February 19, 1997

Ms. Patricia J. Elder, Case Manager
United States Court of Appeals
for the Sixth Circuit
100 East Fifth Street, Rm. 532
Potter Stewart U.S. Courthouse
Cincinnati, Ohio 45202-3988

RE: Your Home Visiting Nurse Service, Inc. v.
Sect. Health & Human Services and
Health Care Finance Administration
Case No. 96-5525
Dist. Court No. 95-CV-276

Dear Ms. Elder:

Enclosed please find a copy of an Administrative Resolution which covered several different years of Owners' Compensation to the Plaintiff/Appellant on the above captioned matter. The Administrative Resolution was entered into on October 4, 1996. The Plaintiff/Appellant filed its reply brief on June 11, 1996. I would like to include the Administrative Resolution as a late filed exhibit to the Plaintiff/Appellant's reply brief. Please let me know the procedure I should follow to accomplish this filing.

Please contact me to advise.

Sincerely,

/s/ Diana L. Gustin
Diana L. Gustin

DLG/bsl

Enclosure
cc: Ms. Betty Leake, YHVNS
Mr. Howard Lewis, DHHS

BlueCross BlueShield Association

An Association of
Independent Blue Cross
and Blue Shield Plans

676 North St. Clair Street
Chicago, Illinois 60611
Telephone 312.440.6023
Fax 312.440.5950

Bernard M. Talbert
Associate General Counsel

Via Facsimile

October 4, 1996

Mr. Gene Barnett
Medicare Audit & Reimbursement
Blue Cross and Blue Shield of
South Carolina
P.O. Box 199190
Columbia, SC 29202

Re: Your Home Visiting Nurse Service
PRRB Case No. 89-0277G and subsequent years

Dear Gene:

Thanks for the proposed Administrative Resolution for Your Home Visiting Nurse Service (YHVNS) as well as the October 4, 1996 letter to Diane Gustin. I thought you did a great job of coming up with a practical approach to a difficult case. Please accept this letter as BCBSA's formal approval.

If you have any questions, please call.

Very truly yours,

/s/ Bernie Talbert
Bernard M. Talbert

cc: Diana Gustin, Esq. (*Via Fax*)

[LOGO]
Medicare
Palmetto Government Benefits Administrators

Audit and Reimbursement
Post Office Box 100190
Columbia, South Carolina 29202-3190

October 4, 1996

Diana Gustin
Attorney At Law
First Tennessee Plaza, Suite 2001
800 South Gay Street
Knoxville, Tennessee 37929

Re: Your Home Visiting Nursing Services
Compensation Appeal
Provider Number: Various
FYE: 12/31/87, 12/31/90, 12/31/91,
12/31/92, 12/31/93 and 12/31/94
PRRB Case Numbers: Various

This letter is to confirm the resolution of the PRRB cases for the above listed FYEs. The parties have agreed that the amounts listed on the attachments to this letter titled "YHVNS' Owners Compensation – Proposed Administrative Resolution" and "YHVNS' Owners' Compensation Proposed, Pension Expense" will be allowed. Additionally, the Intermediary agrees that any interest applicable to the overpayment involved with these adjustments will be refunded pursuant to 42 CFR 405.376 and Provider Reimbursement Manual Section 2219.5(B). Further, the Intermediary agrees to expedite the reopening of the applicable cost reports.

This agreement will need to be affirmed by the Blue Cross and Blue Shield Association. You should receive this by

Monday, October 7, 1996. If you have any questions or if you do not receive the BCBSA's official approval, please give me a call at home at (803) 787-6287 or at Palmetto GBA at (803) 788-0222, extension 26227.

Sincerely

/s/ Gene Barnett
Gene J. Barnett, Esq.
Provider Appeals Specialist
Medicare Audit and Reimbursement

cc: Bernard Talbert, Esq., BCBSA

YHVNS' OWNERS' COMPENSATION – PROPOSED ADMINISTRATIVE RESOLUTION

Betty Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	154,407	130,051	141,000	10,949*
1993	165,152	122,114	132,000	9,886*
1992	163,401	114,661	124,000	9,339*
1991	141,065	107,663	117,000	9,337*
1990	115,568	101,092	109,000	7,908*
1989	NA			
1988	NA			
1987	92,139	71,331	86,000	14,669

Richard Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	135,246	96,913	99,000	2,087*
1993	130,675	90,998	93,000	2,002*
1992	123,463	85,444	87,000	1,556*
1991	108,729	56,893	82,000	25,107*
1990	79,468	43,804	77,000	33,196
1989	N/A			
1988	N/A			
1987	70,324	32,884	60,000	27,116

Rick Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	59,556	44,150	51,000	6,850*
1993	55,895	41,455	48,000	6,545*
1992	45,609	38,925	45,000	6,075*
1991	36,943	36,943	42,000	0

1990	39,216	34,318	39,216	4,898
1989	N/A			
1988	N/A			
1987	16,009	14,663	16,009	1,346

(worked only part of year)
*An additional amount will be allowed to partially reverse the adjustment made to pension expense based on salary. Will compute after salary is approved. Generally an additional 15% will be added, but for some years the entire allowable pension expense was not incurred.

Pension Expense

Betty Leake

	Comp. Adj. (See other Attachment)	Pension Reopening Adjustment
1994	No pension adjustment was made	
1993		955
1992	9,339	1,346
1991	9,337	1,401
1990	7,908	1,186

Richard Leake

1994	No pension adjustment was made	
1993	2,002	300
1992	1,556	224
1991	25,107	3,766
1990	33,196	4,979

Rick Leake

1994	No pension adjustment was made	
1993	6,545	982
1992	6,075	875
		16,015